Allison Lesko, DDS
2001 S. Shields St, Bldg L
Fort Collins, CO 80526
(970) 221-5115
Thefortcollins.dentist

This Acquaintance Form will help us to serve you better. We will do our best to make your appointments as convenient and pleasant as possible. Please feel free to ask our staff if you have questions regarding your treatment, your appointments, or fees. We are glad you are here!

PLEASE PRINT

Mr /Mrs / Miss _____ Birth Date _____
First Name Middle Initial Last Name Month Day Year

Home Phone Number _____ Soc. Sec. No. _____

Home Address _____ City _____ Zip _____

E-Mail Address _____ Cell Phone _____

Employer _____ Business Address _____

Business Phone _____ Present Position _____

Spouse Name _____ Soc. Sec. No. _____

Employer _____ Birth Date _____

Business Phone _____ Business Address _____

Dental Insurance Co. _____ Insured's Employer _____

Insurance Co. Address _____ Phone# _____

Group or Plan No. _____ Subscriber ID# _____

Person Responsible for Bill _____ Birthdate _____

Relationship to you _____ Soc. Sec. No. _____

Billing Address _____ City _____ Zip _____

Emergency Contact: _____ Phone _____

Relationship to you: _____

Whom may we thank for referring you to us? _____

APPOINTMENTS: We work by appointment only so your wait will be minimal and your treatment done efficiently. To help us serve you better we ask for 2 business days notice for changes in your appointment.

INSURANCE: To avoid misunderstanding regarding dental insurance, we want our patients to know that all professional services rendered are charged directly to the patient and that patients are personally responsible for payment of fees. We will prepare necessary forms or reports to help you obtain your benefits from insurance companies. We do not render our services on the basis that insurance companies will pay all our fees. Each fee is individual for the individual patient.

SIGNATURE _____ **DATE** _____

THE FORT COLLINS DENTIST, ***Family & Implant Dentistry***
2001 S. Shields St, Bldg L Fort Collins, CO 80526

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name: _____

Address: _____

Telephone: _____ E-mail: _____

Social Security Number:_____

SECTION B: TO THE PATIENT – PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of you protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in out Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact Person: Dr. Allison Lesko Telephone: 970-221-5115 Email: dr.allisonlesko@gmail.com

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

SIGNATURE: I have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to y our use and disclosure of my protected health information to carry out treatment, payment activities and health care operations. I agree that the office of The Fort Collins Dentist, Family & Implant Dentistry can collect, use and disclose personal information about (patients name)_____ as set out above in the information about the office's privacy policies.

Signature: _____ Date: _____

Optional Consent

(Allows us to discuss treatment of finances with *parents, *spouses,* secretaries, etc. as you designate)

I agree that the office of The Fort Collins Dentist, Family & Implant Dentistry can discuss treatment, arrange appointments, discuss fees, and make financial arrangements.

With: _____ Signature: _____

With: _____ Signature: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.

THE FORT COLLINS DENTIST
family & implant dentistry

Allison Lesko, DDS
2001 S. Shields St, Bldg L
Fort Collins, CO 80526
(970) 221-5115
Thefortcollins.dentist

Patient Full Name: _____ **Birth Date:** _____

DENTAL HISTORY

Please check the appropriate boxes if you currently have, or have experienced:

□ Tooth sensitivity hot, cold, or sweets
□ Tooth pain when chewing or biting
□ Cracked or Chipped teeth
□ Bleeding gums, How long? _____
□ Pain or soreness in gums
□ Food impaction
□ Unpleasant taste or breath odor
□ Swelling, infection or bumps in mouth
□ Loose teeth
□ Clenching or grinding
□ Jaw joint soreness / pain around the ear area
□ Clicking or popping in the joint when eating
□ Burning tongue
□ Previous orthodontic (braces) treatment
□ Wear a removable dental appliance
□ Mouth breathing or Dry mouth
□ Do you snore?
□ Sleepy throughout the day while working, driving or reading. Persistent tiredness.
□ Have you had a sleep study?
□ Oral habits (nail biting, cheek biting, etc)
□ Dental anxiety
□ Any bad experiences in a dental office?
_____

Dates of Last Dental Exam_____ Gum Disease Screening_____ Oral Cancer Screening_____

What is the primary purpose of today's visit? Any concerns?_____
_____

How important is your dental health to you, with 10 the highest rating? 1 2 3 4 5 6 7 8 9 10
Where would you rate your current dental health, with 10 the highest rating? 1 2 3 4 5 6 7 8 9 10
How would you rate the appearance of your smile, with 10 the highest rating? 1 2 3 4 5 6 7 8 9 10
If not a 10, please describe what you would want to improve: _____
_____

How often do you brush your teeth? _____
Do you use an Electric Toothbrush? _____

What other dental aids do you use?

□ Floss
□ Mouth rinse, which one _____
□ Water Pik
□ Other_____

What treatments are you interested in learning about?

□ Orthodontics (braces) or Clear Braces
□ Implants (replacing missing teeth)
□ Dentures or Partial Dentures
□ Sedation (anxiety-free sleep dentistry)
□ Gum Disease Treatments
□ Cosmetic Dentistry or Veneers
□ Teeth Whitening
□ Sleep Apnea treatments
□ Denture Stabilization
□ Headaches or Head/Neck/Jaw Pain

PLEASE TURN OVER AND COMPLETE OTHER SIDE. THANK YOU.

MEDICAL HISTORY

Are you being treated by a physician now? _____ For what?_____
Date of last Physical Exam?_____
Name of Physician_____ Address_____
Physician's Phone_____City _____
My Pharmacy of Choice: _____ Phone # _____
Have you been hospitalized in the last 5 years? For what?_____

HAVE YOU EXPERIENCED:

Yes	No	Chest pain (angina)	Yes	No	Frequent Dizziness
Yes	No	Swollen ankles	Yes	No	Ringing or Pain in ears
Yes	No	Recent weight loss, fever, night sweats	Yes	No	Frequent Headaches
Yes	No	Persistent cough, coughing up blood	Yes	No	Blurred vision
Yes	No	Bleeding problems, or bruising easily	Yes	No	Seizures
Yes	No	Sinus problems	Yes	No	Excessive thirst
Yes	No	Difficulty swallowing	Yes	No	Frequent urination
Yes	No	Diarrhea, constipation, blood in stools	Yes	No	Dry mouth
Yes	No	Frequent vomiting or nausea	Yes	No	Jaundice
Yes	No	Difficulty urinating, or blood in urine	Yes	No	Joint pain, stiffness, arthritis

DO YOU HAVE OR HAVE YOU HAD:

Yes	No	Heart disease, or attack	Yes	No	Autism, Schizophrenia, psychiatric care
Yes	No	Heart murmur	Yes	No	Tumors or Cancer
Yes	No	Rheumatic fever	Yes	No	Radiation or Chemotherapy treatments
Yes	No	Heart Valve problems	Yes	No	Alzheimers or Dementia
Yes	No	Stroke, Stent or hardening of arteries	Yes	No	Parkinson's or Neuromuscular Diseases
Yes	No	Prosthetic Heart Valve	Yes	No	HIV Positive
Yes	No	High blood pressure	Yes	No	AIDS
Yes	No	High Cholesterol	Yes	No	Eye diseases or glaucoma
Yes	No	Pacemaker	Yes	No	Sleep Apnea
Yes	No	Diabetes	Yes	No	Skin diseases
Yes	No	Asthma	Yes	No	Anemia
Yes	No	Emphysema, COPD, Lung disorders	Yes	No	Venereal Disease
Yes	No	Tuberculosis	Yes	No	Canker Sores or Cold Sore/Fever Blister
Yes	No	Kidney, Bladder or Liver Disease	Yes	No	Hospitalization
Yes	No	Hepatitis A, B, or C	Yes	No	Blood transfusions
Yes	No	Stomach problems, ulcers, colitis	Yes	No	Antibiotic pre-med prior to dental care
Yes	No	Thyroid or Adrenal Disease	Yes	No	Artificial Joint or replacement
Yes	No	Depression, or Anxiety Disorders			

SURGERIES: _____

ALLERGIES to medications, latex, food_____

ARE YOU USING?

Yes	No	Tobacco or Cannabis Products	Yes	No	Do you use Antacids
Yes	No	Alcohol	Yes	No	Consume grapefruit or grapefruit extract
Yes	No	Recreational Drugs			
Yes	No	Bisphosphonates (for Osteoporosis / Bone) such as: Fosomax, Boniva, Actonel, Zometa, or Aredia?			

Please List All Current Medications (Prescription, Over-the-Counter and all Supplements)

_____
_____

WOMEN ONLY:

Yes	No	Are you pregnant or nursing	Yes	No	Taking birth control or hormone pills

ALL PATIENTS:

Yes No Do you have or have you had any other diseases or medical problems NOT listed on this form?
If so, please explain_____

To the best of my knowledge, I have answered every question completely and accurately, I will inform my dentist of any changes in my health and/or medication.

PATIENT SIGNATURE:_____DATE:_____